Healthcare Reform: The Impact In Louisiana

Presented by:
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HAFA
Health Agents for America

The Employer's Perspective

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Timeline of Changes

- Early retir… rei…
- Hig… pools

- OTC drug reimbursem…
- HSA …
- Emp… notification requ…ents

- Comparative Effectiveness Research Fee
- FSA limits to $2,500
- Itemized medical expense deduction changes
- Medicare tax increase
- Part D drug subsidy deduction eliminated
- Employee Exchange notification

6/23/10	9/23/10	1/1/11	1/1/12	1/1/13	1/1/14+

- Coverage ex… …on mandates
- Pati… …ections

- **W-2 Reporting** (begin implementation for 2012 W-2s)
- **Internal and External Claims and Appeals Procedures** (generally, 1/1/2012)
- **"CLASS" …m** (su…ed)
- **SCOTUS …** (June 2012)
- **Summary of Bene… Coverage** (open enrollments … after 9/23/2012)
- **Women's … Services** (plan years beginning on … August 1, 2012; certain exemptions apply)
- **Medical L… Ratio Distributions** (August 2012)
- **Quality of Care Reporting** (guidance due March 2012)

- Employer and individual mandates
- Insurance exchanges
- Patient protections
- "Cadillac" excise tax (2018)

Key Provisions Currently in Place

- **Coverage for adult children to age 26**
- **Prohibition on lifetime dollar limits on essential benefits**
- **Restriction on annual dollar limits on essential benefits**
- **No pre-existing condition exclusions on children under 19**
- **No cost sharing on certain preventive care (non-GF plans)**
- **Internal claims and appeals and external review (non-GF plans) — rolling effective dates**

Key Provisions in 2012

- W-2 reporting requirement
  - For employers issuing more than 250 Form W-2s in prior year
- Summary of Benefits and Coverage
  - Notice of Modification 60 days prior to change mid-year
- Contraceptive coverage required (non-GF plans)
- Patient-Centered Outcomes Research Fee (CER fee)
- MLR rebates from fully insured plans (due by August 1st)
- Internal claims and appeals and external review (non-GF plans) —continuation of effective dates

W-2 Reporting

Visit our Employer W-2 Toolkit at:
http://ajg.adobeconnect.com/w_2_pkg/

- **Report the aggregate cost of employer sponsored coverage for 2012 (Reflected on W-2 given in Jan. 2013)**
  - **Include both employer and employee paid portions**
  - **Various valuation methods**
  - **Terminated employees – any consistent reasonable method**
  - **Not necessary to report on 2012 W-2 if requested prior to 2013**
- **Only Informational – No Tax**
- **Exempt until further notice for filers filing less than 250 W-2s**
- **Sample W-2: Report in Box 12, Code DD**

Health Coverage that Must be Included

- **Medical**
- **Prescription drug**
- **Dental** ***(integ. w/medical)***
- **Vision** ***(integ. w/medical)***
- **Hearing**
- **Healthcare FSA** ***(employer contributions)***
- **EAP***
- **Wellness benefits***

if a health plan and COBRA charged

- **Specified disease or hospital indemnity insurance unless 100% employee paid on an after-tax basis**
- **On-site medical clinic***
- **Executive medical**
  - **Physicals**
  - **Supplemental health**
- **Medicare supplement coverage** ***(limited to employers with fewer than 20 employees)***

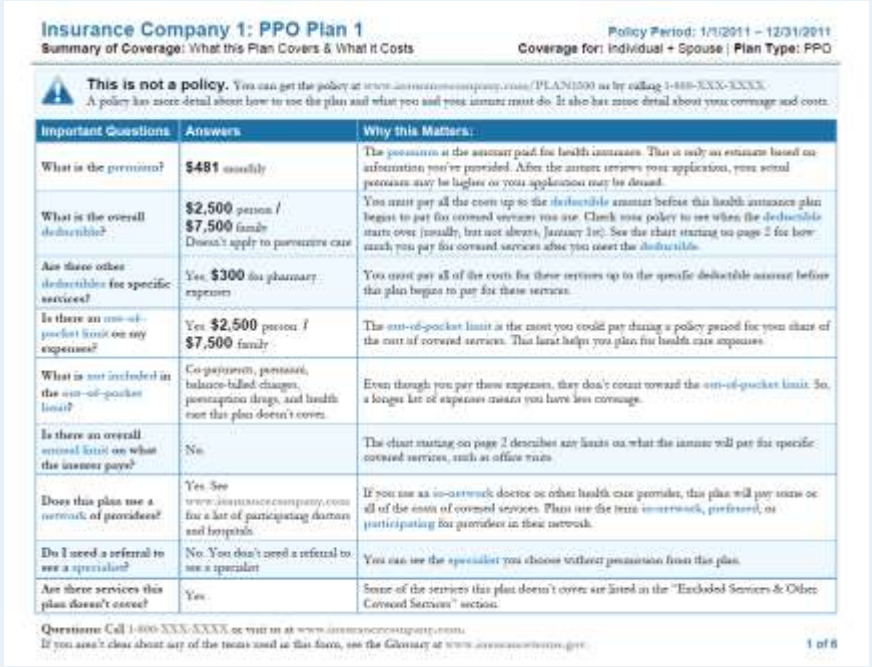
Appeals & External Review

- **New updated rules on internal appeals process for coverage determinations and claims**
  - » **New rules do NOT apply to grandfathered plans**
  - » **New rules DO apply to non-federal governmental plans**
  - » **Insured plans – Insurer must update**
  - » **Self funded plans – Plan sponsor must adopt/update current ERISA claim appeals rules**
- **Must include external review process**
  - » **Insured plans – Most will comply with State process**
  - » **Self funded plans**
    - ▪ **Plan sponsor must establish process**
    - ▪ **“Safe harbor” available until Federal process established**
    - ▪ **Can voluntarily comply with State process if State approves**

Appeals & External Review

- **Limited Delay**
  - **"Culturally and linguistically appropriate" benefit denials - plan years starting on or after 1/1/12**
  - **Strict adherence with claim and appeal requirements - plan years starting on or after 1/1/12**
  - **Additional benefit denial content - plan years starting on or after 7/1/11**
- **Urgent care claim determination - ASAP but no later than 72 hours, not 24 hours**
- **Diagnosis and treatment codes in benefit denials - upon request only**

Summary of Benefits and Coverage



Insurance Company 1: PPO Plan 1
Summary of Coverage: What this Plan Covers & What it Costs

Policy Period: 1/1/2011 – 12/31/2011
Coverage for: Individual + Spouse | **Plan Type:** PPO

This is not a policy. You can get the policy at www.insurancecompany.com/PLAN1500 or by calling 1-800-XXX-XXXX. A policy has more detail about how to use the plan and what you and your insurer must do. It also has more detail about your coverage and costs.

Important Questions	Answers	Why this Matters:
What is the premium?	$481 monthly	The premium is the amount paid for health insurance. This is only an estimate based on information you've provided. After the insurer reviews your application, your actual premium may be higher or your application may be denied.
What is the overall deductible?	$2,500 person / $7,500 family. Doesn't apply to preventive care	You must pay all the costs up to the deductible amount before this health insurance plan begins to pay for covered services you use. Check your policy to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.
Are there other deductibles for specific services?	Yes. $300 for pharmacy expenses	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
Is there an out-of-pocket limit on my expenses?	Yes. $2,500 person / $7,500 family	The out-of-pocket limit is the most you could pay during a policy period for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Co-payments, premiums, balance-billed charges, prescription drugs, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit. So, a longer list of expenses means you have less coverage.
Is there an overall annual limit on what the insurer pays?	No.	The chart starting on page 2 describes any limits on what the insurer will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes. See www.insurancecompany.com for a list of participating doctors and hospitals.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Plans use the term in-network, preferred, or participating for providers in their network.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed in the "Excluded Services & Other Covered Services" section.

Questions: Call 1-800-XXX-XXXX or visit us at www.insurancecompany.com.
If you aren't clear about any of the terms used in this form, see the Glossary at www.insurancecompany.gov.

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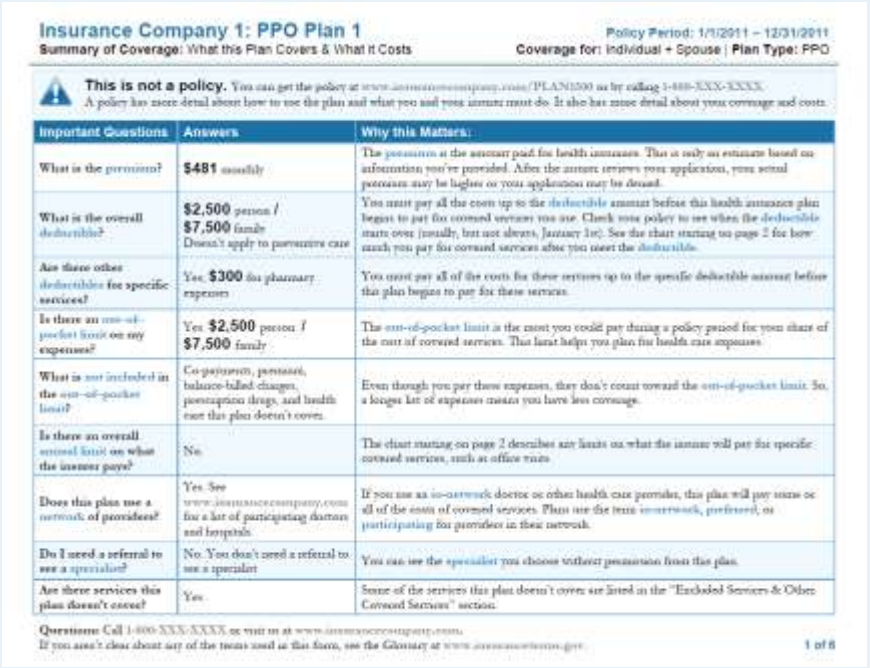
- **New disclosure requirement**
- **Summary of certain key provisions of health plan coverage**
- **Must provide using HHS format**
  - **Limited to 4 pages, 12-point font**
  - **Language must be understandable by average plan enrollee**
    - **Counties in which at least 10 percent of the population is literate only in the same non-English language**
    - **Translated templates are available**

Summary of Benefits and Coverage



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- **Applies to all group health plans, group insurance policies, and individual policies**
  - » **Excepted benefits are not included**
- **Effective dates**
  - » **Open Enrollments: Beginning on or after 9/23/12**
  - » **New Enrollees: First day of plan year beginning on or after 9/23/12**
- **Glossary of Terms**
  - » **Includes standard definitions of certain insurance-related terms**
  - » **Developed by the NAIC**
  - » **Notice must be provided at least 7days after a request**
  - » **The generic definitions may not be sufficient to help enrollees understand plan terms**

Women's Preventive Services

- **Guidelines for Women's Preventive Services for non-grandfathered plans**
  - **First plan year beginning on or after August 1, 2012**
  - **Limited "religious employers" are exempt**
  - **Broader group of church-related organizations (e.g., schools, hospitals, charities, etc.) have one-year safe harbor from enforcement**
- **Include:**
  - **Gestational diabetes screening**
  - **HPV DNA testing**
  - **Sexually Transmitted Infection counseling;**
  - **Contraception and contraceptive counseling;**
  - **Breastfeeding support, supplies, and counseling;**
  - **Domestic violence screening**
- **Currently require well-woman visits without cost-sharing by non-grandfathered plans**

Quality of Care Reporting

- **Annual Report Regarding Quality of Care**
  - **Disclosure of group health plan reimbursement structures that improve the quality of care, including wellness and health promotion activities, by non-grandfathered plans**
- **Must be provided to:**
  - **Plan participants**
  - **HHS**
- **When:**
  - **Annual basis**
  - **Made available to enrollees during each open enrollment period**
  - **HHS to make publicly available on internet**
  - **Regulations were to be developed no later than March 23, 2012**

Medical Loss Ratio Rebates

- **Fully-insured plans only**
- **ERISA plans: Is it a plan asset? Were there employee contributions?**
  - **DOL Technical Release 2011-04**
  - **First, check the plan documents**
  - **If plan documents silent, then follow general rules in Technical Release**
  - **Key is determining what portion of rebate is a plan asset**
- **Nonfederal governmental plans: If participants contributed, then proportionate share of rebate should:**
  - **(1) Reduce participants' portion of premium in subsequent year; or**
  - **(2) Provide cash refund to enrolled participants in the coverage at the time rebate is received**
- **Church plans: Rebate paid to employer if agree in writing to reduce premium or payout to participants. Otherwise, rebate distributed directly to participants of the group health plan**

Small Employer Tax Credit

- **Employers with fewer than 25 FTEs may qualify for a premium tax credit**
  - **Must pay an average wage of less than $50,000 a year, and**
  - **Pay at least half of employee health insurance premiums (for employee-only coverage)**
- **Credit is 35% (25% for tax-exempt organizations)**
  - **Sequestration reduced the credit by 8.7% for certain tax-exempt organizations**
- **Must obtain coverage through an Exchange in 2014 in order to qualify for the credit**

Timeline of Changes: 2013

- Early retir… rei…
- Hig… pools

- OTC drug reimbursem…
- HSA …
- Emp… notification requ…ments

- **Comparative Effectiveness Research Fee** (plan years ending after 9/30/2012; fee is paid in following year)
- **FSA limits to $2,500** (certain plans may need to consider implementing change early)
- **Itemized medical expense deduction changes**
- **Medicare tax increase**
- **Part D drug subsidy deduction eliminated**
- **Employee Exchange notification**

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- **Internal and External Claims and Appeals Procedures** (generally, 1/1/2012)
- **"CLASS" LT** …pended)
- **Summary** … **Coverage** (open enrollments beginning on or after 9/23/2012)
- **Women's Preventive Services** (plan years beginning on or after August 1, 2012; certain exemptions apply)
- **Medical Loss Ratio Distributions** (August 2012)
- **Quality of Care Reporting** (guidance due March 2012)

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- Insurance exchanges
- Patient protections
- "Cadillac" excise tax (2018)

Comparative Effectiveness Research Fee

- **Comparative Effectiveness Research Fee**
  - » **Finances Patient-Centered Outcomes Research Trust Fund**
  - » **Effective for plans years ending after 9/30/12**
    - **e.g., plan year that ends on 12/31/12 is included**
  - » **The fee is payable annually and is due by July 31 of the calendar year immediately following the last day of the plan or policy year**
    - **e.g., the fee for the impacted 2012 plans will be due on July 31, 2013**
  - » **Pay $1 per participant/enrollee annual fee for first year**
  - » **$2 (indexed) for following years**

FSA Contribution Limitation

- **New Limit**
  - » **Annual employee contributions to healthcare Flexible Spending Accounts limited to $2,500**
    - **UPDATE: Effective with plan years beginning on or after January 1, 2013**
    - **UPDATE: Cafeteria plan documents must be amended by December 31, 2014**

Tax on Med Device Manufacturers

- **Annual excise tax on medical device manufacturers**
  - **New excise tax of 2.3% on the sale of medical devices by manufacturers, producers, or importers**
  - **Eyeglasses, contact lenses, hearing aids, and any device generally purchased by the public at retail for individual use is exempted**
- **Applies to sales made after December 31, 2012**
- **JCT estimates additional revenue of $20 billion over a ten-year period**

Employer Explanation of Exchange

- **Notice of Explanation of Exchange**
  - **Premium assistance is available if plan value is below 60% of total benefit cost**
  - **Employee purchase of policy through Exchange results in loss of employer' contribution to group health plan**
- **To whom:**
  - **Current employees and new hires**
- **Effective date:**
  - **March 1, 2013 effective date delayed**

2014: The Year of Big Changes (Maybe?)

- Early retir… rei…
- Hig… pools

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- HSA …
- Emp… notification requ…ments

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- **Women's Preve… …vices** (plan years beginning on or after August 1, … …ertain exemptions apply)
- **Medical Loss R… …Distributions** (August 2012)
- **Quality of Care Reporting** (guidance due March 2012)

- **Employer and individual mandates**
- **Insurance exchanges**
- **Patient protections**
- **"Cadillac" excise tax (2018)**

Employer Reporting of Health Insurance Coverage

- **Who:**
  - Applicable Large Employers and Offering Employers
- **What:**
  - Whether employees can enroll in "minimum essential coverage" under employer-sponsored plan and other information such as waiting period, premium cost and ER contribution, & number of FTEs
- **To whom:**
  - The IRS
- **When:**
  - Periods beginning after December 31, 2013
- **Effective date:**
  - December 31, 2013

Patient Protections

- **Non-grandfathered plans:**
  - » Cannot discriminate based on health status
  - » Small group insured plans
    - Must provide essential benefits
    - Deductibles must not exceed limits for qualified high deductible health plans ($2,000 individual/$4,000 family in 2014); indexed annually
  - » Out-of-pocket limits cannot exceed applicable limits for qualified high deductible health plans ($6,250 individual/$12,500 family for 2013)
    - – Applies to both fully insured plans and self-funded plans
- **New Date for MLR Rebates**
  - » September 30 instead of August 1

Patient Protections

- **No waiting periods longer than 90 days**
  - NOT first of the month after 90 days!
  - Effective first plan year on or after January 1, 2014
- **Elimination of Pre-existing Condition Exclusions for all**
  - In 2014, a plan may not impose a pre-existing condition exclusion on any enrollee
  - Reminder: Effective for the first plan year beginning on or after September 23, 2010, plans could no longer impose pre-existing condition exclusions on enrollees under the age of 19
  - Carriers estimate 2% to 4% increase in costs
- **Non-grandfathered plans cannot deny participation in a clinical trial**
  - Applies to clinical trials to treat cancer or other life-threatening diseases

Patient Protections

- **Removal of Annual Dollar Limits on Essential Health Benefits**
  - **Effective for the first plan year beginning on or after September 23, 2010, plans may only impose an overall annual dollar limit on Essential Health Benefits**
    - **Waiver request required for mini-med plans through 2013**
  - **Even the "limited" annual limits must be removed in 2014**

Transitional Reinsurance Fee

- **Transitional Reinsurance Fee**
  - **Intended to stabilize premiums by partially offsetting claims for high-cost individuals in non-grandfathered individual market plans**
  - **Insured and self-funded plans**
    - **Fee paid by TPA in case of self-funded plans, but plan responsible for funding payment**
  - **Payments**
    - **UPDATE: Nov. 30 proposed regulations would provide fee due annually (submit enrollment count by 11/15, HHS responds by later of 15 days later or 12/15, payment due 30 days later; e.g., 1/15/2015, but could be as early as 12/31/2014)**
  - **Payment amount**
    - **UPDATE: Nov. 30 proposed regulations set fee amount at annualized rate of $63/member/year**

Annual Fee on Health Insurance Providers

- Fee based on market share of net premiums written
  - » No fee on first $25 million
  - » 50% of premiums between $25 million and $50 million subject to fee
  - » 100% of premiums in excess of $50 million taken into account
- Fee does not apply to self-funded plans, federal, state or other governmental entities
  - » Schedule:
    - $8 billion in 2014
    - $11.3 billion in 2015-2016
    - $13.9 billion in 2017
    - $14.3 billion in 2018
    - Indexed thereafter (amount from previous year increased by rate of premium growth)
  - » Fee must be paid no later than September 30 of each calendar year (specific date TBD)
- JCT estimates $60.1 billion additional revenue
- Effective 2014
- Estimated rate increase of 1% to 3%

Employer Shared Responsibility

Have at least 50 FTEs?

NO → **No penalty applies!**

YES ↓

Offer Coverage?

NO → **$2,000 penalty per full-time EE (minus first 30) if at least one full-time EE receives the tax credit**

YES ↓

Plan provides minimum required value?

NO → **Lesser of:**
- **$3,000 per full-time EE receiving tax credit***
- ***Or***
- **$2,000 per full-time EE (minus first 30)**

YES ↓

Is coverage affordable?

NO → **Lesser of:**
- **$3,000 per full-time EE receiving tax credit***
- ***Or***
- **$2,000 per full-time EE (minus first 30)**

YES ↓

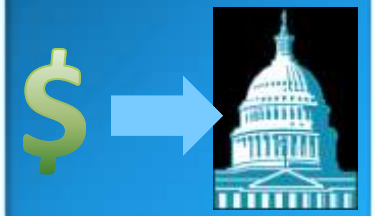
No penalty applies!

** Only applies to full-time employees with household incomes of between 100% and 400% of FPL*

"Cadillac" Tax – 2018

COBRA Rate ≥ $10,200 for individual or
$27,500 for family

Excise Tax



= 40% of plan value that exceeds threshold

Special Provisions

- **High risk professions**
- **Early retirees**
- **Age & Gender**

Watch List

- **Automatic enrollment**
- **Quality of care reporting**
- **Nondiscrimination rules**

The Individual's Perspective

Limitation on Itemized Deductions

- Beginning in 2013, 7.5% floor for itemized unreimbursed medical expenses for those under age 65 raised
  - In 2007, about 7% of tax returns reported a deduction for medical expenses
  - Increased by 1% in 2008
  - Of those, taxpayers with AGI below $50,000 accounted for roughly 52% of those taking an itemized medical expense deduction in 2007
- Medical expenses include health insurance premiums paid by taxpayer as well as certain transportation and lodging expenses related to medical care, and certain long-term care premiums
- PPACA raises threshold to 10% of AGI for taxpayers under 65
  - Taxpayers over the age of 65 temporarily retain 7.5% limit until 2016
  - JCT estimates $15.2 billion additional revenue

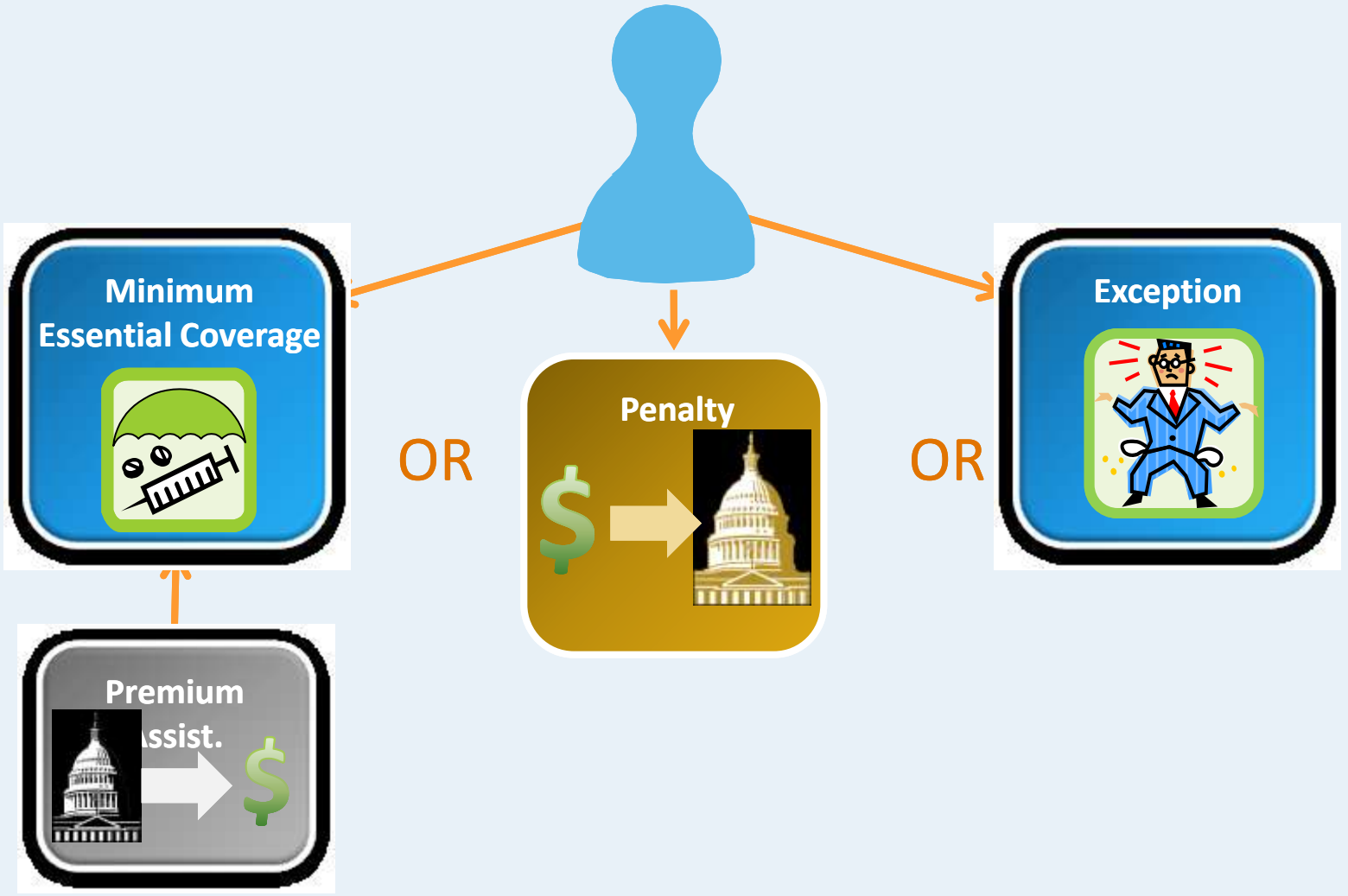
Additional Medicare Payroll Tax

- **Current: 1.45% payroll tax paid by employer and employee to finance Medicare Hospital Insurance (Part A)**
- **New: 0.9% additional payroll tax on high-income workers**
  - **$200,000 for single filers and $250,000 for joint filers**
  - **Married taxpayers filing separately are subject to a $125,000 threshold**
- **Estimate $86.8 Billion additional revenue**

Tax on Unearned Income

- **Medicare**
  - » **Additional tax on net investment**
    - **Net investment includes interest, dividends, non-qualified annuities, royalties, rents, and taxable net capital gains**
    - **Excludes distributions from a qualified annuity from a pension plan**
  - » **Households with Modified Adjusted Gross Income (MAGI) under threshold amounts will not be subject to the investment tax**
  - » **For taxable years after December 31, 2012, the tax will be equal to 3.8% of the *lesser* of (1) net investment income for the taxable year, or (2) the excess of MAGI over $250,000 for joint filers ($125,000 for married filing separately and $200,000 for all other returns)**
  - » **JCT estimates $123.4 billion additional revenue**

Individual Mandate -2014



Individual Mandate

- **The Individual Mandate – Exceptions and Exemptions:**
  - **Unaffordability**
    - **Required contribution exceeds 8% of the individual's household income**
  - **Household income below income tax filing threshold**
  - **Native Americans**
  - **Short lapses**
    - **Lack Minimum Essential Coverage for a period of less than 3 months**
  - **Prisoners**
  - **Undocumented aliens**
  - **Religious Exceptions**
    - **Health Care Sharing Ministry**
    - **Conscientious objections**

Individual Mandate

The Individual Mandate – Tax Filing Threshold

IF your filing status is...	AND at the end of 2011 you were...*	THEN file a return if your gross income was at least...**
single	under 65	$9,500
	65 or older	$10,950
head of household	under 65	$12,200
	65 or older	$13,650
married, filing jointly	under 65 (both spouses)	$19,000
	65 or older (one spouse)	$20,150
	65 or older (both spouses)	$21,300

Individual Mandate

Year	Flat Dollar Amount*	Maximum Penalty is the greater of:
2014	$95	Up to $285 per family or 1.0% of income
2015	$325	Up to $975 per family or 2.0% of income
2016	$695	Up to $2,085 per family or 2.5% of income
After 2016	$695, indexed for inflation in $50 increments	Up to $2,085 per family (indexed) or 2.5% of income

Halved for dependents under age 18 (but do not halve when determining 300% cap on dollar amount for those not insured by taxpayer)

Exchanges – Premium Assistance

- **To qualify for premium assistance credit, an individual must:**
  - Not be eligible for an employer-sponsored plan that is affordable and has a minimum value
  - Have a household income between 100% and 400% of the Federal Poverty Level
  - Not receive benefits through Medicare, Medicaid, CHIP, TRICARE, VA or other coverage as determined by HHS
  - Be a citizen or legal immigrant
  - Be a resident of the state where the Exchange is located
  - Not be claimed as a dependent on anyone's tax return
  - Purchase a qualified health plan through the Exchange (not including a catastrophic plan)

Exchanges – Premium Assistance

- **The amount of the tax credit is based on the premium for the second lowest cost silver plan in the exchange and area where the person is eligible to purchase coverage**
- **The amount of the tax credit varies with income such that the premium a person would have to pay for the second lowest cost silver plan would not exceed a specified percentage of their income (adjusted for family size), as follows:**

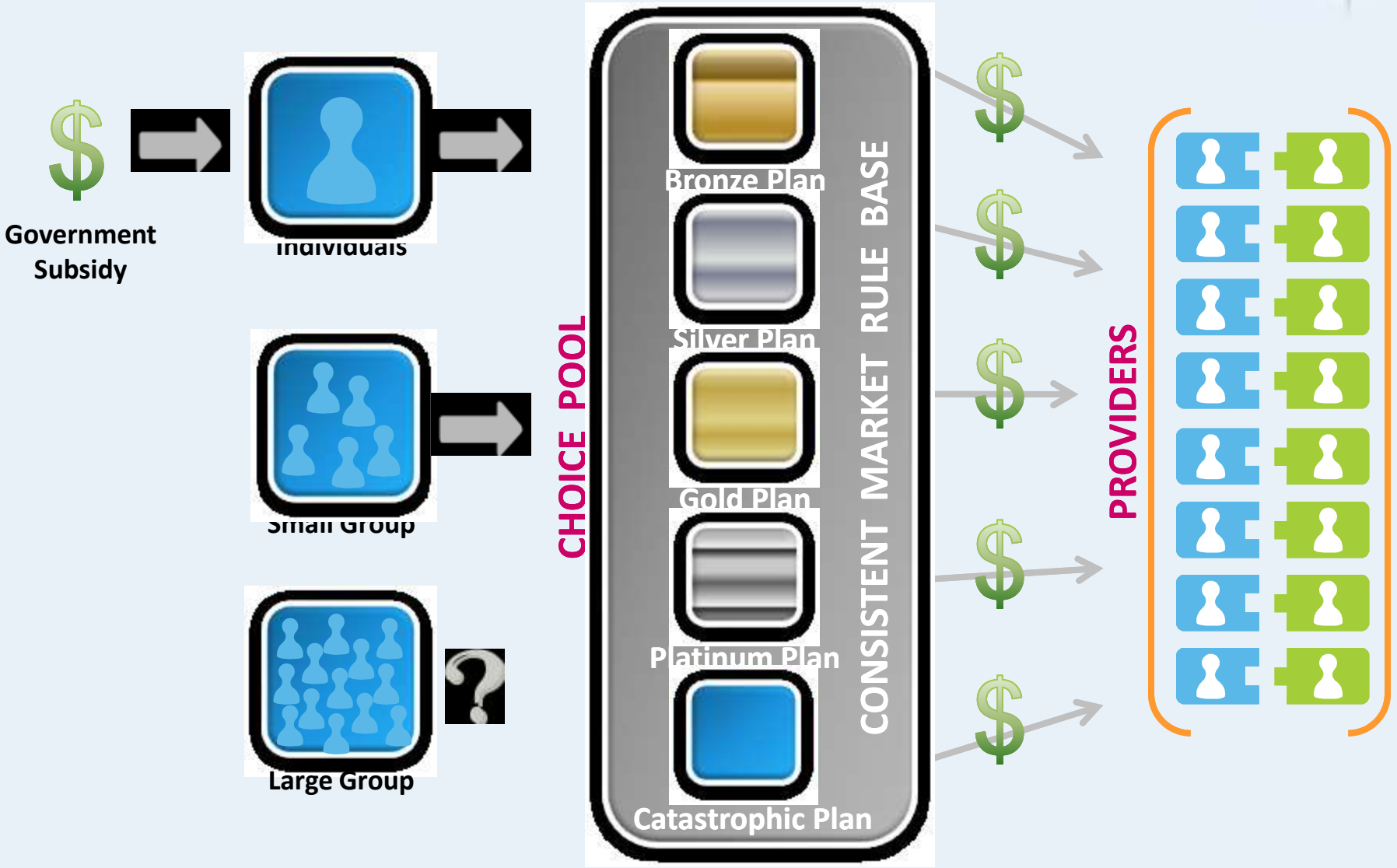
FPL	Income Range	Applicable Portion		
Level 1	< 133%	2.00%	-	2.00%
Level 2	133% - 150%	3.00%	-	4.00%
Level 3	150% - 200%	4.00%	-	6.30%
Level 4	200% - 250%	6.30%	-	8.05%
Level 5	250% - 300%	8.05%	-	9.50%
Level 6	300% - 400%	9.50%	-	9.50%

Individual Mandate

Comparison of Cost in Employer-Sponsored Coverage and Exchange Coverage			
Percentage of Federal Poverty Level		200%	500%
MAGI		$50,000	$124,000
Employer-Based coverage (Premium: $20,000, avg OOP $3,200)	Avg. Marginal Tax Rate	29.4%	38.7%
	Avg. Pre-Tax savings	$5,900	$7,000
	Total Cost (including after-tax premium and OOP costs)	$17,300	$15,500
Exchange Coverage (Premium: $15,400; avg OOP $6,400)	Percentage of income required to purchase lowest cost silver plan	6.5%	N/A
	Premium Subsidy	$12,200	$0
	Cost Sharing Subsidy	$3,600	$0
	Total Cost	$6,000	$21,800

Source: CBO and JCT's Estimates of the Effects of the Affordable Care Act on the Number of People Obtaining Employment-Based Health Insurance (March 2012)

Exchanges



Exchanges - Marketplace

- Employer Notice

- Call Center

- Website

- Navigator

The State's Perspective

State's Perspective

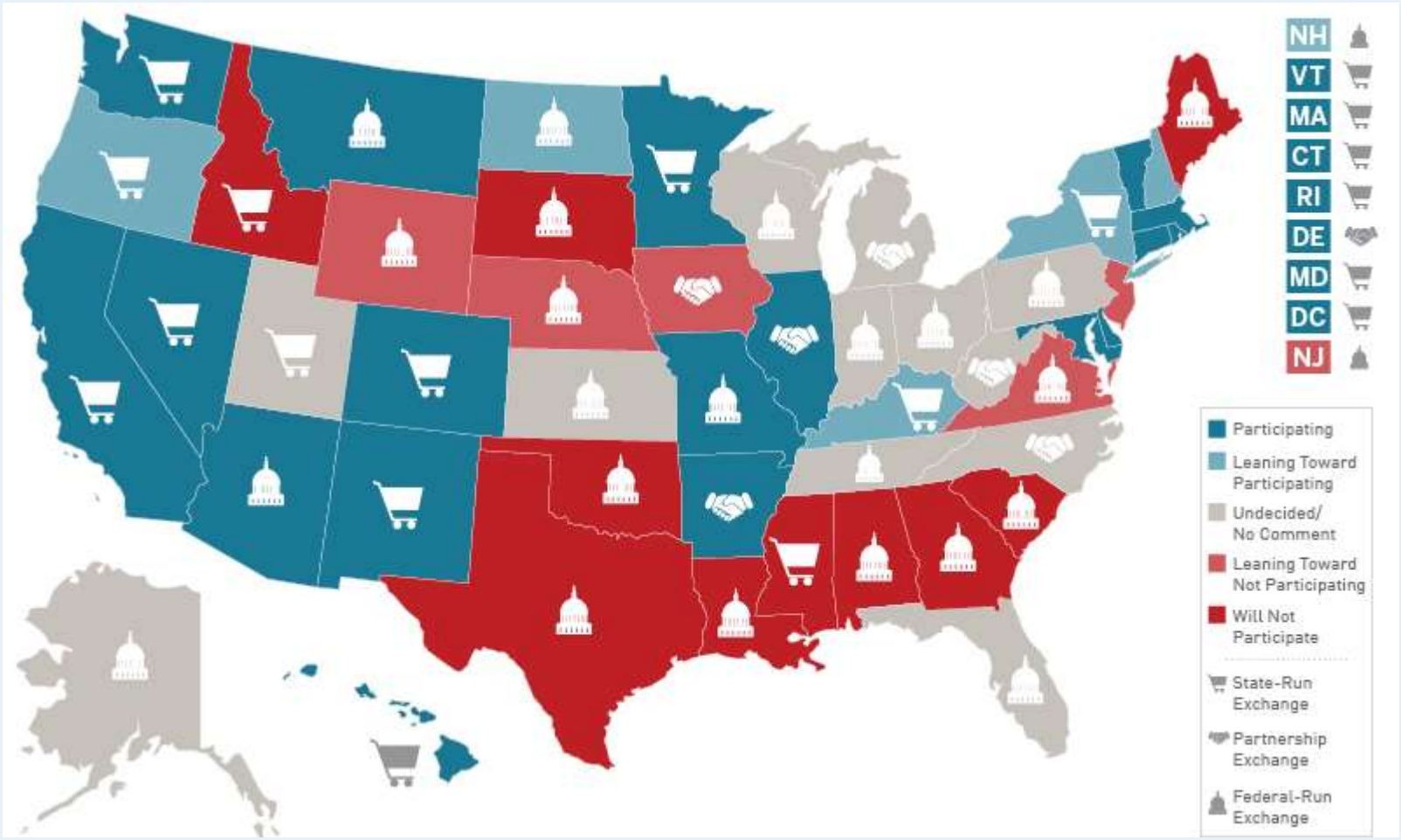
- **Primary Issues**
  - » **Medicaid Expansion**
  - » **Development of Exchange**
- **Secondary Issue**
  - » **Development of Essential Health Benefit Base Plan**

Medicaid Expansion

- **PPACA requires states to expand Medicaid eligibility to include those with household incomes below 133% of the federal poverty level**
  - » **US Supreme Court decision made that provision voluntary**
- **HHS Guidance states that no partial expansion permitted**
- **Arkansas has an unusual plan**
  - » **Purchasing private Exchange coverage with Medicaid funds**

Medicaid.gov
Keeping America Healthy

State Decisions on Medicaid Expansion



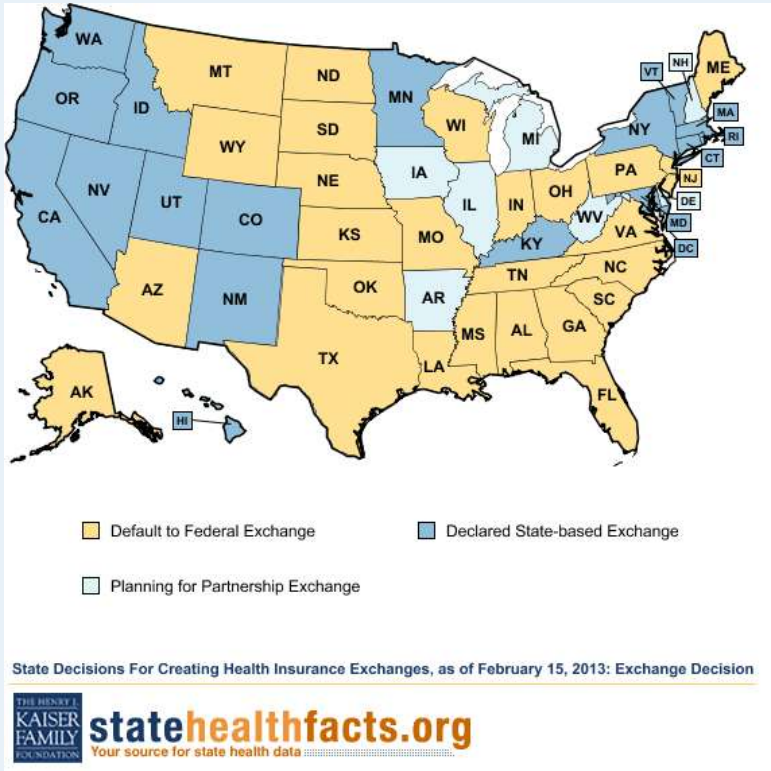
Source: The Advisory Council, www.advisory.com, as visited January 15, 2013

Impact

- **Impact on employers where states say no**
  - **PPACA provides premium credits to eligible individuals and families with incomes 100% - 400% of FPL to purchase insurance through the Exchanges**
  - **Individuals with incomes 100% - 133%/138% of FPL (who might otherwise have been Medicaid beneficiaries pre-SCOTUS ruling) can buy federally subsidized coverage on the exchanges**
  - **Total federal subsidy spending could be greater than originally forecast**
  - **Could result in increased number of employees who could potentially trigger an employer shared responsibility penalty under PPACA (if affordability and/or actuarial value requirements are not met)**

Exchanges

- **Under PPACA, states are required to establish Exchanges as a marketplace for individuals and small business owners to shop for affordable health insurance**
- **Options include**
  - **State-Based Exchange**
    - **16 states + DC**
  - **Federally Facilitated Exchange**
    - **18 states**
  - **State-Federal Partnership**
    - **6 states**



Exchanges

- **Exchanges may either follow "clearinghouse" or "active purchaser" model**
  - **A clearinghouse model means that the Exchange will accept any qualified health plan from any carrier**
  - **An active purchaser model will require that plans meet more stringent guidelines to participate in the Exchange**
- **Under guidance in May 2012, the Federally-Facilitated Exchanges will follow a clearinghouse model**
  - **Also, the federal government will determine eligibility for premium tax credits and create navigator programs**

Exchanges

- **Estimated cost to run an Exchange ranges from $30 million to $81 million per year**
  - » **Funding available to assist a state to set up an Exchange, but not to run an Exchange**
  - » **State Exchanges must be self-funded by January 1, 2015**
  - » **Federally Facilitated Exchange will charge fee of 3.5% of premium to cover costs to run Exchange**

Exchanges

- The deadline for approval of State-Based Exchanges was January 1, 2013
- The deadline for approval of a Partnership Exchange was March 1, 2013
- Exchanges must begin enrollment as of October 1, 2013 (for January 1, 2014 coverage)
- Exchanges must be fully operational on January 1, 2014
- Carriers must submit bids to participate by April 30, 2013

Exchanges

- **Some low income children will be covered by Medicaid or CHIP, and their parents by an Exchange plan**
- **Those children may qualify for premium assistance through Medicaid or CHIP to obtain coverage in the Exchange along with their parents (but their coverage would not be subject to PPACA premium assistance)**

Essential Health Benefits

- **Beginning on January 1, 2014, PPACA mandates that all non-grandfathered health insurance plans in the individual and small group markets (as well as those sold through future Exchanges) provide coverage for ten defined Essential Health Benefits ("EHBs")**
- **The ten EHBs are:**
  - **Ambulatory patient services;**
  - **Emergency services; hospitalization;**
  - **Maternity and newborn care;**
  - **Mental health and substance use disorder services, including behavioral health treatment;**
  - **Prescription drugs;**
  - **Rehabilitative and habilitative services and devices;**
  - **Laboratory services;**
  - **Preventive and wellness services and chronic disease management; and**
  - **Pediatric services, including oral and vision care**

Essential Health Benefits

- States were permitted to designate an EHB Base Benchmark Plan by October 1, 2012
- If state did not select a Base Benchmark Plan, then HHS selects
  - » As of December 4, 2012, 27 states had recommended EHB Base Benchmark Plans
  - » 24 states had a default selection
- Louisiana did not select a Base Benchmark Plan
  - » Thus, the BCBS of LA GroupCare PPO plan was selected as the default plan based upon enrollment

Essential Health Benefits

- States may identify additional benefits for an EHB plan, but the state must make payments, either to the individual enrollee or to the issuer on behalf of the enrollee, to offset the cost of the additional benefits
- The state may avoid the costs associated with these state-required benefits for those benefit requirements enacted prior to December 31, 2011 (even if effective at a later date)

State Activity

- State involvement will continue to be in flux over next few years
- States may decide to expand Medicaid coverage after initially refusing
- States may move from Federally-Facilitated Exchange to State-Federal Partnership
- States should continue to monitor level of involvement desired in Exchanges
- States may provide subsidies for coverage in Exchanges through Medicaid or CHIP programs
- States should become involved in FFE educational outreach

Thank You!

The intent of this analysis is to provide you with general information regarding the provisions of PPACA. It does not necessarily fully address all of your organization's specific issues. It should not be construed as, nor is it intended to provide, tax or legal advice. Questions regarding specific issues should be addressed by your organization's general counsel or an attorney who specializes in this practice area.